American Specialty Health Networks (ASH Netwo...)
P.O. Box 509001, San Diego, CA 92150-9001

INITIAL HEALTH STATUS
(Chiropractic) Fax: 877/427-4777

Patient Name: _____ Birthdate: _____ Sex: M / F

Address: _____ City: _____ State: _____ Zip: _____

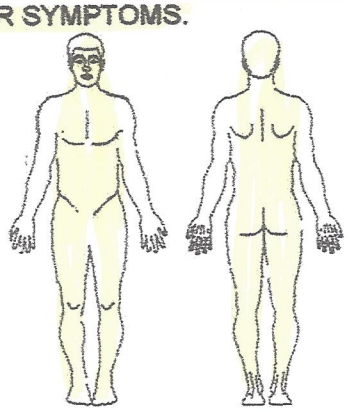
Telephone: _____ Social Security #: _____ Driver Lic. #: _____

Occupation: _____ Employer: _____ Work Phone: _____

[redacted]

Primary Care Physician Name: _____ PCP Phone: _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Low back pain

☐ Other _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began: _____

How Problem Began: _____

Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

How often are your symptoms present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

Can you perform your daily activities? ☐ Yes ☐ No (Describe any current activity limitations) _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ No ☐ Yes **Date(s) taken:** _____

WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: ☐ None Apply

No	Yes	Condition
☐	☐	History of Recent Infection
☐	☐	Recent Fever
☐	☐	HIV/AIDS
☐	☐	Diabetes
☐	☐	Corticosteroid Use
☐	☐	[redacted]
☐	☐	High Blood Pressure
☐	☐	Stroke (date) _____
☐	☐	Dizziness/Fainting
☐	☐	Numbness in Groin/Buttocks
☐	☐	Urinary Retention
☐	☐	Aortic Aneurysm
☐	☐	Cancer/Tumor
☐	☐	Osteoporosis
☐	☐	Recent Trauma

No	Yes	Condition
☐	☐	Prostate Problems
☐	☐	Frequent Urination
☐	☐	Currently Pregnant, # weeks _____
☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Epilepsy/Seizures
☐	☐	Visual Disturbances
☐	☐	Low/Mid Back Pain
☐	☐	Neck Pain
☐	☐	Arthritis
☐	☐	History of Alcohol Use
☐	☐	History of Tobacco Use
☐	☐	Nocturnal Pain (pain at night)
☐	☐	Surgeries _____
☐	☐	Medications: _____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Networks may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Networks to contact my physician, if necessary.

Patient Signature: _____ **Date:** _____

Email Address: _____

How did you hear about us? _____

Nill Family Chiropractic & Wellness Center
Dr. James P. Nill D.C.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment in particular you should note.

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques.
b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore the apparent association is noted very infrequently. However, you are being warned of the possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote.
c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused or may be caused by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of the Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor including spinal adjustment. I intend this Consent to apply to all my present and future chiropractic care.

_____	_____
Patient Signature (or Legal Guardian)	Signature of Witness
_____	_____
Patient Printed Name	Witness Printed Name
_____	_____
Date	Date

Prior Chiropractic Treatment Information

Name of Chiropractor: _____ Location (city): _____

When was your last treatment? _____ Have you had x-rays? _____

4606 W. Jefferson Blvd.
Fort Wayne, IN 46804
Phone: 260-459-2205
E-Mail: dmill@nillchiropractic.com

Family Chiropractic & Wellness C
Dr. James P. Nill D.C.

Nill Family Chiropractic & Wellness Center Consent for Use or Disclosure of Health Information

Nill Family Chiropractic & Wellness Center is concerned with protecting our patients' privacy. While the law requires us to give you this disclosure, please understand that we will always respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health card information.

- We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for diagnosis, assessment or treatment of your health condition.
- We have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to disclose your health information within our practice for quality control or other operational purposes.

Your Right To Limit Uses Or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right To Revoke Your Authorization

You have the right to revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation if we have already released your health information before we received your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I acknowledge that I have received a copy of this notice.

Patient's Printed Name

Patient's Signature

Date

Authorized Provider's Representative Printed Name

Authorized Provider's Representative Signature

{Patient's Representative's Printed Name}

{Patient's Representative's Signature}

{Description of Patient's Representative's authority to act for the patient}

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Date

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Authorized Provider's Representative Signature

{Patient's Representative's Printed Name}

{Patient's Representative's Signature}

{Description of Patient's Representative's authority to act for the patient}

Nill Family Chiropractic
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Nill Family Chiropractic & Wellness Center
Dr. James P. Nill D.C.

Patient Name:_____

ASSIGNMENT OF INSURANCE BENEFITS

I authorize and direct that payment be made directly to:

James P. Nill, DC
Nill Family Chiropractic & Wellness Center. LLC
4606 W. Jefferson Blvd.
Fort Wayne, Indiana 46804

For any and all insurance benefits or reimbursement for services rendered by him which amounts would otherwise be payable to me under any insurance or pre-paid health care plan. This is irrevocable.

_____ _____
Patient Signature Date

PAYMENT AGREEMENT

I understand that there is no guarantee that my insurance company or pre-paid health plan will cover or pay for all of my charges.

Benefits quoted from the insurance companies are not a guarantee of payment until claims are processed and paid. Any procedure or product not covered under your insurance company or pre-paid health plan is the patients' responsibility.

A 2% interest per month will be applied to your account if payment is not received within 30 days of statement date.

Non payment of services rendered will result in accounts being sent to collections after 90 days of original bill/statement. Patients will be liable for all collection costs and attorney fees.

_____ _____
Patient Signature Date

4606 W. Jefferson Blvd.
Fort Wayne, IN 46804
Phone: 260) 459-2205
E-Mail: drnill@nillchiropractic.com

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Dr. James P. Nill D.C.

CANCELLATION NOTICE

I _____, understand and agree that should I fail to show up for my scheduled appointment without a 24 hour notice of cancellation that I am subject to a $30.00 cancellation fee. This fee will be added to my statement and billed directly to me as my responsibility to pay.

Our office understands that emergencies do arise. Should you need to cancel due to an emergency, but rescheduled your appointment with Dr. Nill at that time, the $30.00 fee will be waived. Rescheduling an appointment more than three times will result back to the cancellation fee of $30.00.

_____
Patient Signature

_____
Date

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